

August 25, 2021, Weekly Briefing Transcript

Dr. Podolsky:

Good morning. I'm Dr. Daniel Podolsky, president of UT Southwestern Medical Center and I want to welcome all of those of you joining this morning to this biweekly briefing for the UT Southwestern community.

As our last campus briefing of this fiscal year, I want to take a moment to extend my thanks to all of you in the UT Southwestern community who have done such outstanding work over the course of this year. It certainly has been a challenging one in so many different ways, and yet your commitment and dedication has ensured that UT Southwestern has continued to move forward in all of its mission and in particular to be there to help our patients in our community navigate the pandemic. I know it has been at times a grueling experience, but please know that all of your efforts are deeply appreciated certainly by me, but I can tell you from all that I hear by our community much more broadly.

As we approach the end of the fiscal year, I want to look into the next as well and I plan to share some of our priorities for fiscal year '22 in the coming weeks, including a virtual town hall that we are planning to hold at noon on September 21st. And you'll be hearing more about that ahead of the town hall. Again, it's an opportunity also for you to ask questions directly of myself and of the leadership team here at UT Southwestern. But for now, our attention remains on the present and the changing landscape we are seeing due to the Delta variant and a surge of positive COVID-19 cases across our region and state. So since we have quite a bit to cover this morning, I'm going to begin by a current picture of the pandemic as we see it here in North Texas. Certainly as you heard from past briefings, the Delta variant of the COVID-19 virus has become by far the dominant variant in North Texas, really accounting for more than 95% of new cases.

And as a highly transmissible variant, it is a significant driver of the continuing escalation of new cases that we are seeing in the region and certainly here in Dallas and at UT Southwestern. As of yesterday, nearly 22% of beds in the region broadly are occupied by patients with COVID-19 and just under 50% of ICU beds across the region. Now Dallas County is at somewhat lower levels, but no county is an island, so to speak. And as we see increasing rates in the counties around us, we can't expect to remain in any way kind of out of the general direction that the pandemic is taking in the region.

Positivity for people being tested at hospitals remains at a high level, 17% in Dallas County, somewhat higher in Tarrant County. And as the latest update from our modeling group shows and that was just shared with me last night and will be posted I believe by the end of the day for you to see for yourself, the RT continues to be above one in both Dallas and Tarrant County and that really foreshadows a continued increase in the rate of new cases of COVID-19. Indeed, we are at a pace that will eclipse the highest surge we've seen to date. That's the one that was in this winter and that should occur within the next few weeks here. That is to say in early September.

It is slightly encouraging that the rate of increase on this latest update has somewhat slowed, but I think we can take only I think a small degree of comfort in that because still we are seeing an increase in the

number of positive cases. And with that, the numbers who will be in the hospitals, which always lags a little behind the positivity of the cases and to put significant stress on the healthcare capacity in our region. I was concerned to hear that nearly two thirds of hospitals already are experiencing staffing shortages, which is a greater stress than we have seen in any past surge.

So we have challenges in the week ahead. I think the one encouraging trend that you will see when you review the update from a modeling group is that more and more people are again wearing masks, at least as self-reported. Dallas County leads the way and perhaps that does correlate to a degree in the somewhat lower rates of cases... Excuse me, patients in the hospital beds in Dallas County.

However, as I've said, what we really need to do is really see a broad embrace of wearing masks in the whole region as really the most powerful tool in the immediate short-term for stemming this latest surge. At the same time, of course, we hope that everybody who has not yet been vaccinated will choose to get vaccinated as a longer term solution to the rising tide of new COVID cases. Very glad to say that nearly 82% of the UT Southwestern community is now fully vaccinated, but that still means that 18% or nearly a fifth of UT Southwestern community has yet to benefit from the protection that vaccination does provide.

And I hope you will take this opportunity to do that for yourself, but also your loved ones and the people around you. With respect to the specifics on the campus at Clements University Hospital, we've been caring for 60 plus patients a day over the past week. Yesterday, it was at 68. That's up 24% in the last two weeks and certainly rising numbers of patients we're caring for at Parkland in excess of 140 yesterday, which is a 65% increase in the last two weeks. And as many of you of course will have heard, also with this latest surge, we're seeing more and more patients in the pediatric age group requiring hospitalization and being cared for at our partner children's medical center.

We continue to follow very closely the number of positive COVID-19 cases amongst UT Southwestern employees. Last week, we had 60 community acquired infections, which was somewhat down from the week before. Though, I don't know that as one point in a curve it really suggests any kind of trend. Of some concern to me and certainly members of the EOC is that we are seeing, again, even if it's very small numbers, some transmission on campus. In the past a week of reporting, that included three instances of transmission from one employee to the next in a nonclinical setting and two instances of transmission from one employee to another in a clinical setting.

Even though those numbers are low, that does represent an increase in so far as we went many months without any on-campus transmission. And I think I should add that amongst those, of all of those instances of UT Southwestern employees testing positive, about two thirds were vaccinated. These were breakthrough infections. Now, fortunately, in the majority and almost every instance, those are very mild infection, which brings me to a point I made in our last briefing and I want to underscore once again. Knowing that the vaccine, even if it isn't a guarantee against COVID-19, nonetheless does provide protection against more severe illness. We are learning that in the great many of vaccinated patients who do contract COVID-19, the symptoms are very mild to almost non-existent. So that in many instances, individuals are interpreting what turns out to be symptoms of COVID as something more inconsequential, an allergy.

I want to emphasize if you are experiencing anything that is a change from your usual state of health and any symptom that you might perceive, please stop, consult occupational health. And in most instances, consider or proceed to get a COVID-19 test to be sure that it isn't indeed a breakthrough infection. Now, I do want to note that as of last Friday, all UT Southwestern employees, learners, and trainees can conveniently schedule a COVID-19 test on your own without having to go through Occupational Health. So if you have symptoms, had an exposure, or require testing for any reason, you can just go to MyChart and schedule it yourself.

Testing is still being conducted at our drive-through testing site outside the Bass Center on North Campus. Now, even though you can schedule a test on your own, I still ask that you also continue to fill out the Occupational Health COVID-19 screening form either before or immediately after scheduling your test so that we can keep as close an eye as possible on instances of COVID-19 amongst our employee.

I know another topic that continues to be on many people's minds as we follow it in the media is the vaccine approval and also approval for booster vaccinations. Many of you saw or read on Monday that the FDA issued its full approval for the Pfizer COVID-19 vaccine. And that is for individuals 16 years of age or older. For individuals who are 12 to 16, it still remains under emergency use authorization only. We do anticipate that there will also be full approval of a Moderna vaccine in the next few weeks.

So last week, the CDC issued guidance to provide a third dose of Pfizer or Moderna, depending on the initial vaccine administration, to individuals who are immunocompromised either by virtue of an illness or by medications that they're taking. The justification for this booster was given as "People with moderately to severe compromised immune systems may not build the same level of immunity to two dose vaccine series compared to people who are not immunocompromised." We now have notified approximately 14,000 of our own patients who we know to meet the criteria as immunocompromised and have been offering same-day appointments on our West Campus for those eligible persons to receive their third dose. Once the CDC approves a third dose of Pfizer or Moderna for people who are not immunocompromised, which we expect will be later in the month of September, we will work to operationalize that as quickly as possible, including providing means for our own UT Southwestern community to get that third dose to boost their immunity.

But to come back to a point I made in my earlier comments, if you've not received the vaccine yet, please choose to make an appointment online to receive the vaccine on our West Campus. But at the same time, I can't emphasize too strongly the power and the value of masking in the meantime. And we have as, as you will all be well aware, a requirement for masks for anybody working in one of our clinical facilities or visiting our clinical facilities. And we also strongly encourage masking indoors, even if you're vaccinated, in all of our non-clinical areas as well.

With that, I do want to touch on some of the recommendations which have been formulated by our Emergency Operations Community, the EOC, reviewed by myself and the EVPs and endorsed. And it's in the context of the rising number of new cases in our community, albeit small numbered, but nonetheless an increase in the number of on-campus transmission. And in consideration of that, the committee has recommended and I have accepted that for events or meetings of 10 or more persons scheduled between now and at least the end of October, those meetings should be held on a virtual format. So let me, again, emphasize we are directing that gatherings on the campus be no more than 10

individuals where there is a virtual format alternative. And for those meetings that are in-person and are less than 10, still would emphasize that they should include only those people who really need to be in the meeting. And we should be really looking for opportunities to minimize even the smallest chance of transmission where there's not a value to be derived from another person in the room, so to speak.

Now, before wrapping up and turning to your questions, I want to touch on a few non-COVID matters. And first, to remind you that the period for nominations for our Leaders in Clinical Excellence Award for 2021 is still open for another two weeks. These awards were established in 2018, kind of following on the inaugural award that goes back to 2009, which is the Watson Award for Clinical Excellence. And now with a broader menu, as it were, of awards to recognize exceptional efforts in the care of our patients as well as the education training of the next generation of healthcare professionals, I do hope you'll stop and think about the great examples of great care that you've seen, including teamwork, to recognize teams that are delivering care as well as individuals, and examples of mentoring.

The nomination should be submitted online. And the nominating period is through Wednesday, September 8. And the website or the address for submitting those are utswmed.org/why-utsw/clinicalawards. The nominations will be reviewed by a faculty awards committee, once again co-chaired by doctors Maeve Sheehan and John Mansour, and awards will be conferred later this fall.

And in wrapping up, I do want to make note of some leadership changes that are imminent now on our campus. First at the end of this month, the 31st, is Leah Hurley, our VP for legal affairs, will retire after 30 years of outstanding service to UT Southwestern. I'm sure I speak on behalf of the whole campus in both thanking her for that service in support of our mission and wishing her well in retirement. Also to congratulate Aaron [Sine 00:16:14], who will take over the reins on September 1st, as our new VP for legal affairs. Also leaving the university, I've been informed by Janelle Browne, our vice president for human resources and chief... excuse me, chief human resources officer that she will leave the university at the end of September. I've asked Marc Nivet, Dr. Marc Nivet, our EVP for institutional advancements, to step in and serve as our interim VP for HR and work with the outstanding leadership group and staff of HR, in the important work they do on behalf of the university.

It's my intention to initiate a national search for the permanent successor, but in the meantime, I am sure with Dr. Nivet's leadership and the great staff in human resources, they'll continue to fulfill all of the important roles that they serve in, in really enabling every area of the campus to advance because in the end, the most important thing on this campus, are not the wonderful building and the facilities, but the talent and the commitment of the people who work at UT Southwestern. So with that, I'm going to finish this update and turn to Jenny Doren, who once again, will pose the questions that you forwarded since our last briefing.

Jenny Doren:

Good morning, Dr. Podolsky, we have gained significant experience caring for COVID-19 patients over the past 18 plus months. What treatment strategies are yielding the best outcomes?

Dr. Podolsky:

Well, let me first really underscore the kind of the premise of the question, which is that we have made significant progress and able to deliver better care and outcomes to our patients with all that we have

learned and with all the advances that have made since the pandemic began. And just as an overarching view of that, I think we can all be proud kind of as the metric of the overall quality of care, that the observed mortality compared to the predicted mortality at UT Southwestern for COVID patients is 0.71. Now, that may sound to those who don't think about that observed to expected as a odd or a puzzling metric. But what it's saying is the, almost a third of patients, who on average, taken care of in this country, would have died from COVID actually will survive, through the excellent care provided by our healthcare teams at UT Southwestern.

And part of that is we have been deeply involved in, at the forefront in clinical trials that have led to insights into what therapeutics are most effective. And one of the things that we've learned is that the phase of illness, that is the early phase dominated by the virus replicating, versus the later phase when it's more about inflammation responding to the virus, and that phase and the severity disease inform what is the best treatment. To highlight a few of these, for example, monoclonal antibody therapies have proved about 70 to 80% effective at reducing the risk of hospitalization in patients with mild to moderate COVID-19. So, as an outpatient, who is early in the course, monoclonal antibodies are a mainstay of therapy to change and to improve the outlook.

For those who are in the hospital and their COVID is severe enough to require oxygen, we know that the antiviral medication, remdesivir, can shorten the duration of the symptoms or hospitalizations. So, that is a cornerstone of treatment for that group. For those who are more severely ill by the time they seek treatment, or those who do progress even though they've come to the hospital, steroid medications and specifically the steroid, dexamethasone, either alone or with other medications, such as an antibody called tocilizumab, or another drug called baricitinib, reduced the mortality in severe COVID-19 disease. We are also, at this point, still looking at new potential experimental therapies, including apheresis, which is a process to remove some of the more toxic components generated in the course of the illness from the plasma of the individuals affected. And we are actually a leading center in the ongoing study of that new intervention.

And finally, beyond this treatment, whether that's monoclonal antibodies, or the remdesivir, or steroids, and the other drugs, our teams have just through experience became much more skilled in our ability to provide the critical care. And that's a combination of our critical care specialists, our hospitalists, certainly our nursing colleagues and teams, have just learned through experience to deliver expert supportive care, that is really as essential as any of those medications to improving outcome. And having said all that I have about the improvements, all of us can easily, I think, recognize that we still need better treatments because unfortunately, many patients are still dying despite all of the progress. And of course, the number one best treatment for it is prevention. Getting a vaccine is I think the thing that is the most salient that we've learned over the course of the past several months.

Jenny Doren:

Thank you for that. During each of your briefings, you dive into our forecasting model, which we know illustrates how COVID-19 is spreading across the DFW region. How reliable has our modeling been in predicting the future of the virus in North Texas?

Dr. Podolsky:

Well, the UT Southwestern forecasting model has been really remarkably reliable in predicting the trajectory of the outbreak over time, really, predictions, particularly in the short term, that means over the next two and four week period have been, typically, within 4% or so of what has been predicted. And the forecasting focuses heavily on the impact on healthcare due to COVID-19 hospitalizations. The team works primarily on that shorter term forecasting, though, it continues to look at, for any of those who are following these updates as they are posted twice weekly on our website, do look in the longer term as well.

The longer term predictions get modified as circumstances do change. For example, to come back to a point I touched on early in my remarks, as we are seeing more people again wearing masks, that does promise to have some reduction in the worst case scenario in, not necessarily the next two to three weeks, but in the longer term predicted, later in September and into October, if we just look at the [inaudible 00:23:47], at the circumstance. So I want to actually take the opportunity in answering these questions and answer the question to really thank the work of the modeling team. It brings together scientists, physicians from many departments, takes the benefit of some of the investments we've made at UT Southwestern and computing power and our supercomputer and the BioHPC resource to provide these predictions, which have helped us and policymakers and others through the region, really make plans that match the circumstances as they evolve.

Jenny Doren:

There's a lot of heightened interest in our modeling, which shows people are engaging with it, which is great news there. The latest COVID models do show, as you mentioned, cases peaking in DFW around October and then declining.

Why is the decline anticipated? Is it because at that point, most people will either be vaccinated or infected? Can you explain?

Dr. Podolsky:

The short answer is yes to both but let me provide some more context. As we've seen throughout the pandemic, COVID cases and hospitalizations tend to come in distinct waves, which then lead to declines with intervening periods of lower cases before a new peak arrives.

In most cases, what drives a new peak has been changes in our behavior around masking, social distancing, and travel and those have often coincided, as I think everybody will appreciate, with events like holidays or the summer of travel.

Now, the other variable that has informed those patterns has been the rival of new variants of concern, and in particular variants, which as they've emerged, have been more easily spread from person to person, or may have the ability to cause more reinfection in those who are previously infected or partially escape the vaccine immunity.

For example, the large spike in the winter was driven by the Alpha variant, which was about 50% or so more transmissible than the original virus. The current spike is driven by the Delta variant, which is significantly, even more transmissible.

So just as there are multiple factors that lead to a spike, there are multiple factors that can lead to the subsequent decline. These include the changes in behaviors, such as increased masking, a social distancing and reduction in travel and we have seen some early trends and as I touched on already, we've seen some early trends of changes in some of our tracking, likely caused by increased public awareness of the surge in cases and that seems to be especially true in Dallas County, relative to the surrounding counties.

As we're well aware, increased vaccine uptake also helps dramatically curb cases. Although it is important to remember that those who are just now starting their vaccine series will not be fully vaccinated for about five weeks or two weeks after the second dose and part of the models anticipated decline is on the expectation, as we are seeing, that some increase in the number of people deciding now to become vaccinated will contribute to that decline.

I can only hope that those who have been concerned that the vaccines up until now were only released under an emergency use authorization will be reassured that they have gotten the full FDA approval and that will further contribute to the factors which can lead to the subsequent decline of the current surge.

Jenny Doren:

I want to now return a question that I pose two weeks ago and has been raised again and not because that person wasn't listening, but curious whether or not there's been any change and that involves our hospital visitor policy.

At what point would we consider once again, limiting the number of visitors?

Dr. Podolsky:

Well, first of all, let me assure the person asking this question and the campus as a whole, that the visitor policy at Clements University Hospital is really assessed on a continuing basis.

We are certainly focused on maintaining the highest level of safety for our patients, but while also understanding the value that family and close friends have in a loved one's care. UT Southwestern patients and families have benefited in many ways from our current policy and not restricting visitation to the same degree as other health systems. That has been the overwhelming feedback we received.

As I mentioned two weeks ago, there is a high volume of published research on how loved ones serve as trusted advocates and decision-making partners during critical illness. They are a calming and a reassuring presence. For our care teams, they often provide important details that may be missing from health records and can pick up on subtle changes in behavior that may precede medical complications.

Operationally, our hospital leadership have been able to manage situations when the number of visitors may have been really excessive and these instances, however, have been really very limited.

We also continued to require masking in all clinical environments, including patient rooms and have additional screening upon entry to our hospitals and clinics. As yet throughout the pandemic, there have been extremely few instances where visitor transmission has been suspected to have occurred in our hospital.

That being said, we continue to consult with our infectious disease and infection prevention teams, really on an ongoing basis, and we'll adjust our policy as needed. As Dr. Warner, EVP for Health System Affairs, has informed teams in the hospital, if we do get to higher thresholds of census with COVID-19 patients, particularly more than 80 in our hospital overall or 36 in the ICU, we may need to scale back some of our operations and that may mean reducing the number of visitors.

Jenny Doren:

Dr. Podolsky, we have time for one more question. Before I get to that, I do want to encourage people to continue to post their questions. While we may not be able to get to all of them during these briefings, they do help inform our communications moving forward.

So with that, one of our colleagues raised a question that we have heard others in the general public pose. We want to help educate.

Why should those who previously had COVID-19 need to be vaccinated? Shouldn't they already be protected?

Dr. Podolsky:

Certainly a natural infection with SARS-CoV-2 virus does lead to some protective immunity. Based on current estimates from the experience during the course of the pandemic, that immune protection is quite strong for at least three months, possibly longer, but does a taper off thereafter. The level of immune protection after natural infection appears to be much more variable than the immunity that we see after somebody has received a vaccine.

It's important to note that the CDC has published studies from Kentucky, that demonstrate that those who were previously infected and then received a vaccine, were more than two times less likely to get reinfected with the virus than those who had prior infections but were not subsequently vaccinated. So I think that and the recognition that these variants of interests like Delta, Gamma and Lambda, seemed to be more prone to cause reinfection, I think provides a pretty compelling case for getting a vaccine, even if you've had a natural infection.

Jenny Doren:

Thank you so much.

Dr. Podolsky:

Thank you, Jenny, and look forward to sharing an update again with the campus two weeks from today.